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16 May 2009

C+D

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Swine-flu chaos

Hundreds of thousands dead, panic buying of OTCs – how will you cope in a full-blown pandemic?

See pages 10 and 11

PLUS

Are you ready for the hayfever season?

PRESCRIBING INFORMATION
Fexofenadine Hydrochloride
Telfast 120mg film-coated tablets
Presentations:
[illegible] tablets are film-coated peach coloured tablets containing 120 mg [illegible] fexofenadine hydrochloride, equivalent to 112 mg of fexofenadine
Indications:
[illegible] of symptoms associated with seasonal allergic rhinitis.
Dosage & Administration:
[illegible] seasonal allergic rhinitis in adults and children aged [illegible] recommended dose of fexofenadine hydrochloride is [illegible] before a meal. The efficacy and safety of fexofenadine hydrochloride [illegible] established in children under 6 years of age.

Contra-indications:
Known hypersensitivity to any of the product's ingredients.
Precautions:
Studies in adults have shown that it is not necessary to adjust the dose of fexofenadine hydrochloride in the elderly or in renally or hepatically impaired patients. However, fexofenadine should be administered with care in these special groups.
Side effects (Please refer to the Summary of Product Characteristics for full side-effect details):
In controlled clinical trials the incidence of commonly reported adverse events observed with fexofenadine was similar to that observed with placebo. These adverse events were headache, drowsiness, nausea, dizziness, and sleep disorders or paronina, such as nightmares.
In rare cases rash, hypersensitivity reactions with manifestations such as angioedema, chest tightness, dyspnoea, and systemic anaphylaxis have also been reported
Pregnancy & Lactation:
Fexofenadine is not recommended in pregnancy or for mothers breast-feeding their babies, due to absence of experience in this group of patients.
Legal Category: POM
Marketing Authorisation Number: PL 04425/0157
NHS Price: Pack of 30 Tablets: £ 6.23
Further information is available from Winthrop Pharmaceuticals, One Onslow Street, Guildford, Surrey. GU1 4YS.

Date of Revision of Prescribing Information: April 2009

Winthrop
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Adverse events should be reported and information about adverse event reporting can be found on www.yellowcard.gov.uk
Adverse events should also be reported to Winthrop Pharmaceutical UK Ltd as follows:- Email: uk-drugsafety@sanofi-aventis.com Tel. 01483 554242 Fax.:01483 554806

For further information please visit our website www.winthrop-pharma.co.uk, freephone 0800 854431 or contact Winthrop Pharmaceuticals, 1 Onslow Street, Guildford, Surrey, GU1 4YS. Fax number 01483 554831. Date of Preparation April 2009 STW 374

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> THE NEWS THAT PARLIAMENT HAS UPDATED LEGISLATION TO ALLOW PHARMACISTS TO MAKE EMERGENCY SUPPLIES IS A WELCOME BOOST

Three-quarters of a million people dead, panic buying of OTC medicines, fears over stock shortages and widespread pharmacy closures.

It may well sound like fiction but this is exactly what the UK could be facing in just six months' time. The official projections of the chaos that pharmacists will have to deal with in a worst case scenario for a pandemic do not make for pleasant reading.

Our special report (p10) pulls no punches as it predicts how a pandemic could unfold and the struggle that pharmacists – as frontline practitioners – could face in maintaining an essential pharmaceutical service.

So the news that Parliament has updated legislation to allow pharmacists to make emergency supplies of up to 30 days is a welcome boost ahead of a possible full-blown pandemic (p4).

But what this fails to address is just how this will be funded. Asking patients who are exempt from prescription charges to pay for a five day emergency supply can be trying at the best of times. Quite how pharmacists can get them to pay for a month's supply is another matter.

PSNC says the original proposal included a request for funding but there does seem to be a more obvious solution. If pharmacists are authorised to make a supply for up to 30 days, then they should be authorised to fill in an NHS form similar to an FP10 for the supply, which the patient then completes or pays for as they would normally do.

This does not mean that pharmacists are 'prescribing' beyond their capabilities, as filling out an 'FP10-type' form is technically just the admin to support the emergency supply process.

If we can be trusted to use our professional judgement to supply POMs, then completing a prescription form as part of the process makes sense. It is an auditable record of supply, which includes the patient's signature, and it means pharmacists can be paid via the normal route without having to wait for the pandemic to end before chasing GPs to supply several hundred prescriptions to cover the emergency supplies.

Of course, you do need to have the medicines in stock to make the emergency supplies in the first place. And as PSNC and the BAPW have highlighted this week (p4), this is not as easy as it sounds. The two organisations have called for emergency ring-fenced stock to ease the supply shortages that contractors are facing. While this is a positive move, ultimately it's just tinkering around the edges and does not address the underlying issue of supply chain quotas.

As the threat of a widespread pandemic remains a possibility, pharmacists are ready to step up to the swine flu challenge – but this will be so much more difficult without strong central action to deal with the more immediate problems the industry faces.

Gary Paragpuri, Editor

Features

TABPI Awards 2008
Winner for news coverage

Emergency supply powers boosted in legal shake-up

Pharmacists can now make emergency supplies of up to 30 days

Chris Chapman

Pharmacists can now make emergency supplies of up to 30 days without a prescription as part of an overhaul of medicines legislation triggered by the swine flu outbreak.

The legal shake-up permanently raises the maximum quantity of medicine allowed to be supplied at the request of a patient from five to 30 days' treatment. Controlled drugs available in this way remain restricted to five days. Other rules governing emergency supplies and restrictions on medicines that can be supplied remain in place.

The increase in supply length, originally touted in last year's pharmacy white paper, comes as part of a package to support pharmacists in an influenza pandemic.

Other powers granted by the legislation will only apply if a pandemic is declared. These include relaxing the need to interview the patient before an emergency supply is made, and the dispensing of Tamiflu without a prescription if the pharmacy is designated as an antiviral collection point.

The shake-up of emergency supply is part of the DH's pandemic planning

However, question marks remain over the funding of the emergency supply service. PSNC head of pharmacy practice Barbara Parsons said that while emergency supply remained a non-NHS discretionary service, she was optimistic funding could be found.

She said: "The original proposal to extend to 30 days included a request for funding arrangements... now that regulations have been changed we hope to make progress."

An RPSGB spokesperson confirmed that emergency supplies would "continue to be regulated in the current manner". The law currently requires that all emergency supplies are recorded in the POM register.

Further legislative changes "may also be forthcoming" to facilitate contingency planning and continuity of medicines supply in a pandemic, a joint statement from the RPSGB, NPA, CCA, PSNC and Guild of Healthcare pharmacists said.

For the RPSGB's latest guidance on the new supply measures, see **www.chemistanddruggist.co.uk**

THE CHANGES

- The quantity of POM medicines supplied at the request of a patient has increased from five to 30 days' treatment
- If a pandemic is declared, pharmacists will not be required to interview a patient directly to make an emergency supply
- An emergency supply can be made at the request of a UK-registered dentist or at the request of a patient who was previously prescribed the POM by a UK-registered dentist.

PSNC and wholesalers demand quota change

Wholesalers should be given emergency ringfenced stock, to ease supply shortages that are "steadily getting worse", BAPW executive director Martin Sawer has told C+D.

His comments follow a joint letter from PSNC and BAPW (British Association of Pharmaceutical Wholesalers), to manufacturers and the DH, which slammed current quota arrangements as "not sustainable", and insisted on improved communications and new emergency stock arrangements.

The BAPW/PSNC proposal would see emergency buffer stock held by the wholesaler rather than the manufacturer. Contingency stock of medicines in short supply, identified by PSNC and the manufacturer, would be ringfenced by a pharmacy's existing wholesalers.

Pharmacies would contact the manufacturer, who would instruct the wholesaler to supply, allowing next day delivery to any UK pharmacy.

Mr Sawer said the letter was sparked by "stringent quotas" set by manufacturers, resulting in pharmacies struggling to gain access to vital drugs.

He said: "Pharmacy [is] experiencing an increasing number of medicines where they can't dispense immediately and can't always guarantee having a stock of some popular medicines."

The proposal was a "simple system" to enable contingency supplies to be dealt with through the normal wholesale chain, Mr Sawer added. **CC**

PCT puts brakes on pioneering cardiovascular service

Pharmacists and PSNC have expressed their disappointment at Islington PCT's decision to stop funding pharmacy cardiovascular risk assessments.

A six-month pilot of the service began last summer, and pharmacists and the LPC told C+D they had understood that the service would continue to run while the pilot was evaluated.

David Kent, chief executive of Camden and Islington LPC, said the public had been very happy to access the service in community pharmacies and that he felt "let down" by the PCT.

Neil Patel, of Arkle Pharmacy, was involved in the pilot and said: "It's a shame, after we received such positive feedback, to have had to take the service away from patients."

PSNC backed the service at its launch and Alastair Buxton, head of NHS services, said it was disappointing to see an interruption between the pilot and wider rollout. He said as many PCTs began work on such risk assessment services, "it seems a retrograde step for one of the early adopters to pull their service".

NHS Islington said it was still analysing the data from the pilot project and needed to discuss follow up assessments due at the end of May. The PCT stressed that tackling cardiovascular disease was a "high priority" and said it expected a decision to be made "shortly". **ZS**

PCT commissioning: 10 top tips for success
See p21

Hepatitis screening pilot launched in five PCTs

Countless lives could be saved by increased access, charity says

Jennifer Richardson

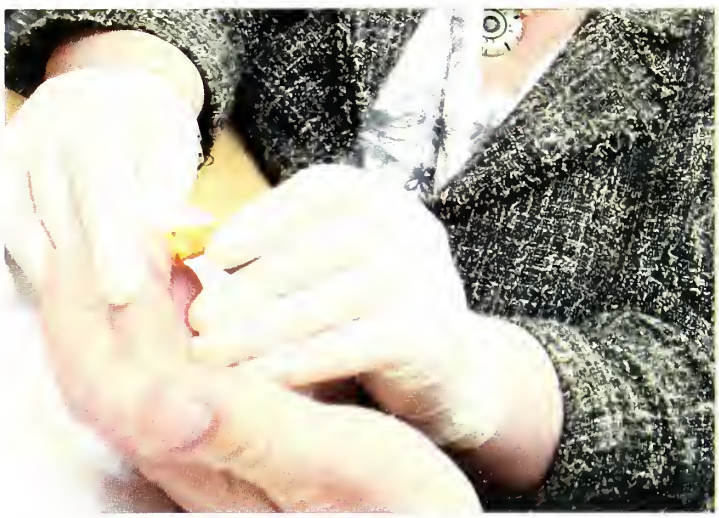
Countless lives could be saved by a ground-breaking hepatitis B and C screening service in community pharmacies, a leading charity has said.

A pilot project developed by The Hepatitis C Trust will see pharmacies in five PCTs across England offering free, on-demand dry blood spot testing for the potentially fatal viruses.

Pharmacists in 19 participating stores have been trained to carry out the tests and give patients lab results. If positive, patients will be referred to their GPs for treatment.

The Hepatitis C Trust hopes the confidential yet accessible community pharmacy setting will persuade hundreds of thousands of potentially undiagnosed hepatitis sufferers in England to come forward for testing. The aim is for the service to eventually be delivered in more pharmacies in all PCTs.

The Hepatitis C Trust's parliamentary and policy advisor Jane Allen told C+D: "We're hoping it's a model that will improve diagnosis rates and can be rolled out nationally."



The Hepatitis C Trust has trained pharmacists to carry out dry blood spot tests

The service will launch on World Hepatitis Day on Tuesday (May 19), and run for three months. In that time, each participating pharmacy will be aiming to carry out 100 tests.

The tests are being funded by the individual PCTs involved (City & Hackney, Nottingham, Sandwell, Tameside & Glossop and Isle of Wight) and remuneration is negotiated locally, with pharmacies being paid between £10 and £15 per test after receiving consumables free of charge. The Hepatitis C Trust has provided the training.

The project was inspired by The Body Shop founder and hepatitis C sufferer Dame Anita Roddick.

RPSGB Council election results

Five new members have joined the RPSGB Council in a close annual election driven by low turnout.

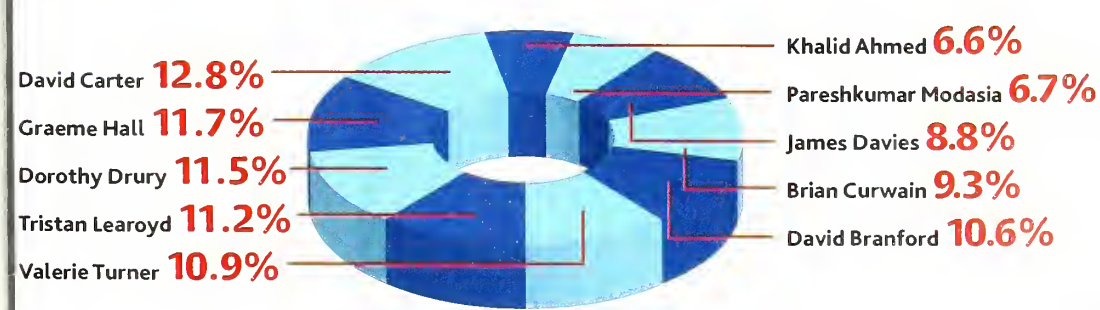
David Carter, Graeme Hall, Dorothy Drury, Tristan Learoyd and Valerie Turner triumphed over five others to claim a Council seat.

However, only 7,357 Society members – 15 per cent of eligible voters – returned their ballot, resulting in a close race in which the nearest runner up, David Branford, missed out on a seat by only 94 votes.

In the national board elections, former Council member Graham Phillips claimed the sectorial pharmacist place in the English board elections, with Gail Curphey and Beth Taylor taking the unreserved places. Former Society president Hemant Patel failed to get enough votes to claim a seat.

Sandra Melville, Derek Stewart, Alpana Mair, Anne Boyter and Stuart Johnstone were elevated to the Scottish board, while Society members in Wales elected Marc Donovan, Edwyn Parry, Peter Jones and Carwyn Jones to their devolved board. The 2009 election was the final Council vote before the professional body and regulator splits in spring 2010. **CC**

RPSGB ANNUAL COUNCIL ELECTION RESULTS



In brief

NCSO endorsements

The Department of Health and National Assembly for Wales have agreed to allow NCSO endorsements for the following items for May: bisacodyl 10mg suppositories; cimetidine 200mg, 400mg and 800mg tablets; and liquid paraffin/magnesium hydroxide oral emulsion S/F.

Inhalers recalled

GSK and the MHRA are recalling batch 1183R of Allen and Hanburys branded Seretide 250 Evohaler due to the possible presence of counterfeit inhalers in the supply chain. The batch of 8ml pressurised inhalers was first distributed in October 2008.

Indecision on RPSGB

Almost 55 per cent of RPSGB members have still not decided whether they will join the new professional leadership body in 2010, a 1,200-strong RPSGB survey showed. Nearly 11 per cent ruled out joining, while the remaining 35 per cent said they did plan to sign up.

AH weight management

Alliance Healthcare's weight management service has been redesigned to allow pharmacy staff to deliver the service as part of a launch in Nottingham. The service, which had been successfully piloted in Coventry two years ago, is also being rolled out in Gwynedd LHB.
www.chemistanddruggist.co.uk

AH statement delays

Alliance Healthcare staff have been "working round the clock" to fix IT problems causing statement delays for some customers, head of customer finance John Jaquiss has said. Contractors complained that the delays had caused cashflow problems by preventing completion of VAT returns.

Tories' PNAs concerns

Conservatives in the House of Lords have expressed concerns over PCTs' ability to control pharmacy contract applications.
www.chemistanddruggist.co.uk

Co-op to defy profit drop

John Nuttall: no change in Co-operative Group's commitment to its pharmacies

The Co-operative Pharmacy boss has emphasised his company's commitment to the business after 2008 results revealed falling profits.

The multiple's underlying profit slumped almost 14 per cent between 2007 and 2008, but Co-operative Pharmacy MD John Nuttall insisted the Co-operative Group would nonetheless continue to invest in the business.

"There is no change to the group's commitment to the healthcare business as one of its core trading businesses," Mr Nuttall said. "It very much ticks the boxes of community values that the group operates on."

Mr Nuttall blamed category M for the 2008 profit drop, and added that the year-end results did not reveal the full impact of the clawbacks. He said: "The impact of category M has hit the business to the tune of £30 million in terms of profit."

The Co-operative Pharmacy would be looking to "maximise business efficiencies" to drive profits back up, Mr Nuttall added. But he reiterated that this would not involve further redundancies in 2009, following the loss of 150 pharmacy staff and further disinvestment in 26 stores late last year. "That really was last year's exercise," Mr Nuttall said. **JR**

Clarity needed on error log sanctions, says PDA

Pharmacists "seriously concerned" about reporting errors, Society says

Jennifer Richardson

The PDA has asked the RPSGB if it intends to take a more lenient approach to pharmacists who do not complete error logs.

The move came after the RPSGB sent members a survey on the records. Early results showed over 40 per cent of pharmacists were "seriously concerned" about reporting errors, the Society revealed, after locum Elizabeth Lee was given a suspended prison sentence following a dispensing error.

But the PDA is concerned the survey could lead pharmacists to believe the Society has now changed its policy of using failure to complete error logs in some disciplinary actions. The PDA has also asked the RPSGB for reassurances that pharmacists who tell the survey they would no longer be reporting errors would not face disciplinary action.

As C+D went to press, Society director David Pruce said there was no change to its error log policy, and confirmed the survey would be anonymous.

Dispensing errors: clarity needed

PDA director John Murphy welcomed the Society's on-record support for the decriminalisation of dispensing errors. But he added: "We are keen to ensure, however, that in its attempts to try and help, it does not trip over its regulatory role and unintentionally create even more professional disciplinary misery for pharmacists."

The PDA has also launched a 'fighting fund' to support its attempts to decriminalise dispensing errors, and has urged pharmacists to attend a London meeting to discuss its strategy on June 7.

The Society hoped to confirm whether or not it would take further disciplinary action against Ms Lee by the middle of next week, a spokesperson said. It has said it is required to deal with the matter under its regulatory responsibilities, but has not yet revealed what this would involve.

You can contribute to the PDA fund

www.conferenceevent.com/campaign_fund.html

An MP has promised to take a PCT to task over late payments to pharmacies, following a Building Bridges visit. Conservative MP Patrick Mercer (Newark and Retford) was the latest politician to join the campaign, visiting Manor Pharmacy's Bridge Street branch in Newark. When Manor Pharmacy superintendent David Evans highlighted problems with PCT commissioning and payments, Mr Mercer promised to write to the PCT to address the issues. Mr Mercer (pictured, left, with branch pharmacist Nichola Passmore and area manager Steve Carter) was "fascinated" by the pharmacy's needle exchange scheme. He said: "I am extremely grateful to the pharmacy for that work." **JR**

NPA examines ID card options

The NPA is to carry out a full investigation into whether pharmacies could record biometric details of customers applying for new passports or ID cards.

The association said it would examine the business case for involvement and share details with members "to allow an informed decision about participation".

The comments came after the NPA attended a meeting last week with home secretary Jacqui Smith to discuss the possibility of pharmacy being involved in the service.

NPA chief executive John Turk said pharmacies currently providing passport photos would lose this income stream once recording of biometric data was required.

He added: "It would be remiss if we didn't proactively look at the opportunity for pharmacy to be involved in the new way passports will be issued." **ZS**

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References: 1. Oliveira F.A.S. et al.: High *in vitro* efficacy of NYDA® [illegible] containing dimeticone. *J. Europ. Acad. Derm.* [illegible]
3. Heukelbach J. et al.: A highly efficacious pediculicide based on dimeticone: randomized double-blind comparative trial. *Br. J.* [illegible]

Dispensary talk

Would you sign patients up for national ID cards at your pharmacy?

Yeah, why not? Because at the same time it brings people into the pharmacy and lets people know what services pharmacy can provide. I don't have a problem with it.
Amish Patel, Hodgson Pharmacy, Dartford

No. I don't believe in them as a system.
Emma Lawrence, Rowlands Pharmacy, Southsea

Web verdict

Yes 38%

No 62%

Armchair view: 'Big Brother won't be watching you in my pharmacy' seems to be the message this week. Six out of 10 respondents are opposed to government suggestions that pharmacies could be an ideal place to take fingerprints and photos for the national ID card scheme.
Next week's question: How should 30-day emergency supplies be funded? Place your vote at **www.chemistanddruggist.co.uk**

Report is good news for pseudoephedrine sales

Crystal meth accounts for just 0.11 per cent of Class A seizures

Zoe Smeaton

The right of pharmacists to sell pseudoephedrine-based decongestants has been boosted by a Home Office report that found crystal meth seizures remain "rare".

The government attempted to remove pseudoephedrine medicines from pharmacies in 2007 over fears products were being used to manufacture crystal meth.

However, the report, which looked at drug seizures in England and Wales, said there were less than 50 seizures of crystal meth in 2007-08. This accounted for less than 0.11 per cent of the 45,672 Class A drugs seizures in the period.

Cocaine was the most commonly seized class A drug, and there were 960 seizures of methadone, making up more than 100,000 doses.

Sheila Kelly, executive director of PAGB, said the report was "good news" for pharmacy. However, she stressed that there was a need for continued vigilance on the matter.

C+D's Stop the Switch fought to maintain pseudoephedrine OTC

C+D's Stop the Switch campaign helped persuade the MHRA to reconsider plans to remove pseudoephedrine products from pharmacy sale. The drugs regulator opted instead to put restrictions on pack sizes and introduce tougher OTC sales controls with a review of these measures in 2009.

The MHRA's working group on pseudoephedrine will meet to discuss how successful these steps have been in July, C+D understands.

Professor Roger Walker, chair of the MHRA working group on the topic, told C+D no decisions had yet been made on future classification.

"We are not aware of any significant increase in instances associated with purchase in pharmacies," he added.

Pharmacist challenge to striking off fails

A Cheshunt pharmacist has failed in a High Court battle against his striking off for "systematic" alteration of prescription forms and forging GP signatures.

Mr Justice Munby backed the RPSGB's decision in May 2008 to remove Jawid Ahmed Yusuf from the register for breaching the Code of Ethics.

He also ordered Mr Yusuf to pay the Society's £12,500 legal bill following his failed appeal.

In his ruling, the judge added: "It is hardly surprising the Committee felt it appropriate to impose the ultimate sanction. Indeed one might rather have been surprised if it had not."

Mr Yusuf was convicted of five offences of dishonestly falsifying NHS prescriptions in January 2004.

An RPSGB disciplinary committee found the pharmacist guilty of "dishonesty, abuse of trust [and] loss to the NHS". Mr Yusuf had signed forms certifying prescription drugs had been supplied to patients when he knew this was untrue, the RPSGB committee said.

Mr Yusuf had appealed against the disciplinary committee for refusing an adjournment he had sought on the grounds of ill health. He claimed officials had been wrong to proceed in his absence and acted disproportionately in removing him from the register.

However, Justice Munby rejected the appeal. He said: "The chairman acted perfectly properly in refusing an application, which as formulated, verged on the impudent."

Ruling that Mr Yusuf must foot the Society's legal costs, the Judge added: "The appellent was given every opportunity to withdraw without financial penalty. He decided to proceed. He failed." **UKL**

Beauty sales down 15pc

Pharmacy sales across key health and beauty product categories have declined by up to 15 per cent in a year, figures from manufacturer Procter & Gamble show.

But businesses could reverse this trend through better merchandising, said the P&G PharmacyCare team.

Pharmacies were losing out to high street and grocery stores with offers designed to tempt customers wanting to pay less in response to the poor economic climate, P&G said. The national fall in sales of the key categories was just 7 per cent.

"To say [pharmacy toiletry sales] is in decline is an understatement – it's dropping off a cliff," said UK pharmacy manager Joanna Dee.

In contrast, the almost 400 stores now signed up to the PharmacyCare programme – in which P&G revamps member stores' category layout – were seeing up to 20 per cent increases in sales of re-merchandised categories, the firm claimed. **JR**


George Wickham


Ciara Garvey


Vincent Campbell


Andrea Fraklin


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Swine flu: the worst case scenario

How will pharmacy services cope if the swine flu crisis escalates? **Chris Chapman** draws on official worst case projections to imagine how the UK will fare in the grip of a full blown pandemic

Winter 2009. After a summer lull, swine flu returns. The outbreak quickly spreads across the northern hemisphere, engulfing Europe and North America as people travel home after Christmas. The World Health Organization declares a level six pandemic and the UK plan kicks in to gear.

Week one

The government puts the country at pandemic alert level three, indicating there are flu outbreaks. Pharmacies begin to be inundated with calls from patients worried by rumours, hearsay and media speculation.

The EU regulator-approved vaccine, hastily developed after the May 2009 outbreak, is distributed to targeted groups but stocks are limited. Tamiflu is supplied to PCTs from the national stockpile, based on population size. The antiviral is only available for treatment and is no longer used for containment.

Meanwhile, the 24-hour National Flu Line is activated. Around 14,000 non-clinical staff are trained to give a rough diagnosis and authorise the distribution of antivirals from collection points. These are generally away from health centres, but pharmacies are designated as collection points in several areas.

Lessons learned in the May 2009 outbreak mean that communication with pharmacy is improved this time around. Most pharmacists are kept up to speed with events, including the number of cases at a local level, although co-ordination remains poor in some areas.

Initial reports suggest the outbreak has affected around 50 per cent of the population, with a fatality rate of 2.5 per cent. Around 750,000 patients will die during the outbreak.

Weeks two and three

The outbreak spreads to all major population areas. Deprivation, dense living areas and overcrowded public transport aid the spread of infection, placing city-based pharmacies on the front line.

Gradually, the outbreak reaches more rural areas. The UK flu alert rises to level four, its highest possible status, indicating widespread infection. The government does not restrict internal travel, but the Foreign Office advises against travel to other countries with outbreaks.

As swine flu is confirmed in local areas, panic-buying of OTC medicines becomes rife. Schools with a confirmed outbreak are closed, forcing some pharmacy staff to stay at home to look after their children.

Some pharmacies begin to ration drugs in fear of supply shortages, while others stockpile medicines. However, medicines supply remains steady throughout the crisis thanks to resilience planning from wholesalers.

Doctors are inundated with suspected cases, seeing around one in three influenza patients. Around 4 per cent of those affected require hospitalisation, with an average stay of around a week.

Elective surgeries are cancelled to free up an additional 40,000 hospital beds nationally to deal with the crisis.

To ease the burden on primary care, pharmacists take on greater responsibility through 30-day emergency supply legislation. Workload increases exponentially as the number of influenza patients rises.

Week four

Day-to-day pharmacy services become difficult to provide because of an increased number of staff absences. Smaller pharmacies with teams of four or five are hit worst as staff take time off due to illness, childcare or bereavement. The absences last an average of seven to 10 days.

The RPSGB temporarily re-registers experienced persons as practising pharmacists to ease these staffing shortages. However, some pharmacists are deployed to support GPs, and locum support is reduced as hospital pharmacists are unavailable.

Pharmacy closures become a reality. Clusters of stores support each other according to local plans, closing and assigning staff where needed. Strange bedfellows are created as independent contractors work in multiples and vice versa.

Services suffer some disruption as loaned staff adapt to new workflows and computer systems. Many non-essential services are withdrawn to utilise resources.

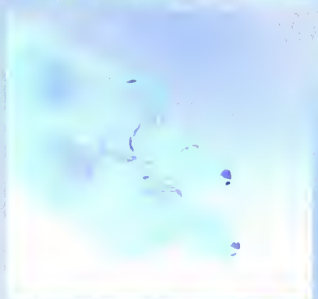
Week five

The reduction in open pharmacies, coupled with staffing difficulties and increased demand, results in queues of angry and frustrated patients.

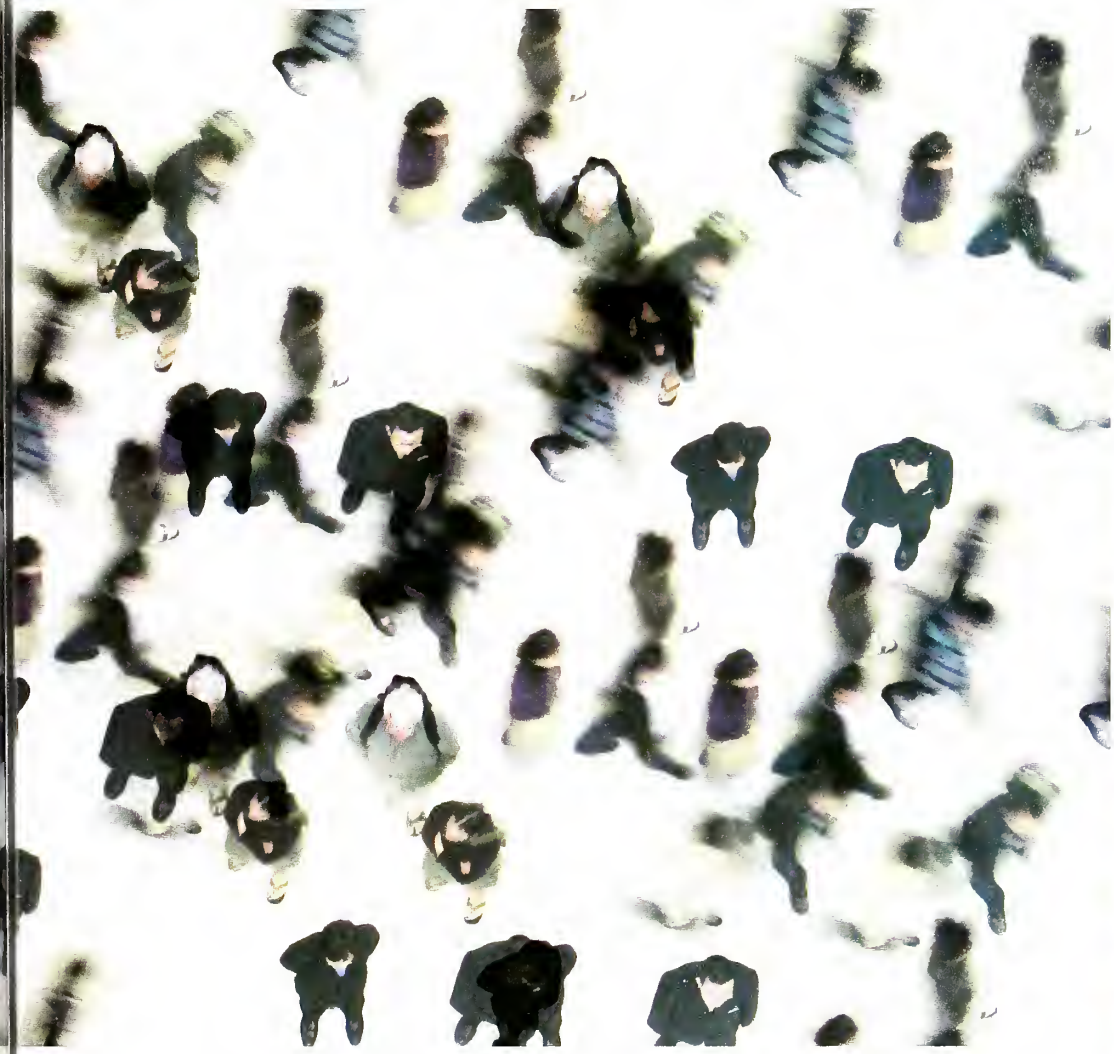
This leads to attacks on pharmacy premises, often by patients desperate to obtain supplies of Tamiflu or the vaccine. The police provide protection, but this is limited due to the reduced number of officers on duty.

Some patients continue to go to work despite their illness, threatening to infect others. Local authorities seek orders from justices of the peace to require

WHO GETS THE VACCINE?



Any vaccine will be prioritised. If a pandemic occurs, priority groups will be decided by the UK National Influenza Pandemic Committee (UKNIPC). Currently the highest priority is assigned to healthcare workers "directly engaged in examination and clinical care of symptomatic flu patients". It is unclear if this includes pharmacists.



the patients to be medically examined. Emergency laws make it a criminal offence for people to expose others to the risk of infection.

As recommended in the UK plan, the armed forces play no part in maintaining order.

Week six

The outbreak hits its peak. Around one in 10 people are affected, with 185 patients per surgery requiring a doctor. Nationally, hospitals can only cope with 25 per cent of the demand for beds. By the end of the week, 168,000 people have died. In Dorset, 80,000 people fall ill, with 2,000 fatalities.

In Worcestershire, pharmacies close according to a plan, collapsing into sustainable clusters.

Meanwhile, some parts of London are hard-pressed. In Wimbledon, only essential pharmacies remain open, selected by location, security arrangements and ability to meet customer demand (such as having multiple IT systems). These pharmacies are put under intense strain by patient demand and increased prescription volume to treat exacerbations.

Aftermath

The number of cases begins to fall, although there are occasional spikes in some areas. Pharmacies reopen as soon as possible and services return to normal. However, some patients' conditions have been exacerbated by influenza, and a backlog of non-essential work remains.

The pandemic ends 15 weeks after it began. Pharmacy has come through with flying colours, holding out and maintaining services in the face of its greatest challenge. Many of the arguments against pharmacists having a greater clinical role have been dismissed, and several of the emergency powers are retained indefinitely.

This is a fictional account of a worst-case swine flu pandemic. However, it is based on actual pandemic flu plans by the government, CCA, PSNC, RPSGB and NPA, and information from BAPW, Lloydspharmacy, Dorset PCT, Worcestershire LPC and grassroots pharmacists.

Flu views

What challenges will you face when a flu pandemic hits?

"Part of the challenge across the piece is finding out what's happening... who's doing what and getting those internal communications to our staff."
Andy Murdock, Lloydspharmacy pharmacy director

"The main thing is the staffing element. People will still want their prescriptions. We need to think about how we're going to share staff, maybe by having one pharmacy with all the staff in the local area."
Raj Patel, Mount Elgon Pharmacy, Wimbledon

POSSIBLE UK DEATHS IN PERSPECTIVE

750,000 – maximum expected deaths in a pandemic flu outbreak

504,052 – registered deaths in England and Wales in 2007

449,800 – British fatalities in second world war

55,000 – minimum expected deaths in a pandemic flu outbreak

12,000 – deaths per year from seasonal flu

179 – UK soldiers killed in the Iraq war

Prescription flatbreads

Livwell is launching a prescription product to coincide with Coeliac Awareness Week. Livwell's 4 Flat Breads are free from gluten, wheat and milk and are an alternative to bread for sandwiches.

Pip code: 339-8583
Polarspeed; tel: 01530 510789

Alvita clarification

Alliance Boots has confirmed that Alvita is a brand of Alliance Healthcare and not Tenscare (see C+D, April 11, p26). The Alvita range includes two new TENS pain relief machines, available to independent pharmacies through Alliance Healthcare.

Alliance Healthcare
Tel: 020 8391 2323

Bimuno on regional TV

Bimuno is appearing on TV screens in the Granada and Scottish regions until June 5. The advertising aims to illustrates how the health supplement can help boost people's natural defences by feeding and strengthening their bodies' own good bacteria.

Clasado; tel: 01908 577850

Venaxx XL launch

Goldshield Pharmaceuticals is introducing a POM product for use in treating major depression. Venaxx XL contains venlafaxine and is available in 75mg or 150mg prolonged release capsules.

Pip codes: 75mg capsules/28 114-6547; 150mg capsules/28 114-6554
Goldshield Pharmaceuticals
Tel: 020 8588 9273

Deep Heat is thinking big

The Mentholatum Company is launching a large Deep Heat patch especially for back pain.

WellPatch Deep Heat Patch for Back Pain is twice the size of the brand's original patch and it features a hinged design, allowing it to be placed comfortably over the lumbar region or other large areas without restricting movement.

The product incorporates improved technology, giving up to eight hours of warming, soothing relief, according to The Mentholatum Company.

It can be placed directly on the skin although it may be placed over clothing for the elderly or those with delicate skin, said the company.

The patch is designed to stay in place without the need for additional taping or strapping.

It comes in a pack of two.

Price and Pip code: £4.29/2, 343-1525
Laser Healthcare 01202 780558

Ease it for the quitters

Smokers are currently being encouraged to take the first steps towards quitting through an 'Ease into quitting' campaign for Niquitin Pre-Quit lozenges.

The £1.6 million campaign is appearing on TV, in national papers and women's magazines.

On air until the beginning of June, the TV advertising features an animation outlining the reasons why smokers may find it daunting to quit and highlights the need for different answers for different quitters.

The lozenges offer pharmacy an opportunity to engage with a different type of quitter who may have delayed or failed to quit, said GSK. A Niquitin Pre-Quit pharmacy education pack is available.

GSK Consumer Healthcare
Tel: 0800 783 3927
www.mypharmassist.co.uk

Football drives footfall

Thornton & Ross has agreed a sponsorship deal for Radian-B with Huddersfield Town FC, which will see the brand logo on the club's away shirt for the 2009-10 season.

The sponsorship is part of a campaign designed to raise consumer awareness of Radian-B topical analgesic treatments, following Thornton & Ross's acquisition of the brand.

The company hopes to encourage new users to trial the products and drive footfall into pharmacies to specifically request the range.

Thornton & Ross
Tel: 01484 842217

Listerine downsizes

Johnson & Johnson is launching small 95ml bottles of its Listerine Total Care and Stay White mouthwashes. The bottles meet airlines' 100ml restrictions on liquids and are suitable for weekend trips or for using a mouthwash on the go.

The launch coincides with National Smile Month (May 17 to June 16) when the British Dental Health Foundation will be promoting ways to enhance oral health routines.

Prices and Pip codes: £0.99/ 95ml; Total Care 344-2639, Stay White 344-2621
Johnson & Johnson
Tel: 01628 822222

Baby biscuits discontinued

Nutricia has discontinued its Cow & Gate biscuits – Animal Friends, Bear and Berry Bear – after a survey by the Children's Food Campaign found the baby biscuits contained hydrogenated fat. "We had planned to discontinue these biscuits from June but have now pulled our plans forward and stopped supplying them to the trade," said a company spokeswoman.

Nutricia; tel: 01225 768381

Benadryl ALLERGY RELIEF

On TV next week

Benylin Allergy Relief: All areas
Bimuno: STV, G
Clarityn: All areas
Compeed Blister Plasters: All areas except GMTV
DulcoEase: GMTV, Sat
Lanacane Anti Chafing Gel: All areas
Levonelle One Step: All areas
Merial Frontline Spot On: All areas except GMTV
NiQuitin: GMTV, five
Touch of Grey: All areas
Voltarol Emulgel: All areas
PharmaSite for next week: LIPObind – windows, **LIPObind** – in-store, **LIPObind** – dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Retail talk

Will you promote the benefits of P hayfever remedies by maximising on PoS material in your window in May?

Yes 48%

No 52%

Off the shelf view: A split vote this week with nearly half of pharmacies making the most of P hayfever remedies as the season gets into full swing. **This week's question:** How do you think your sales of holiday health products will fare if more people take UK holidays this year? Vote at **www.chemistanddruggist.co.uk/prodnews**

It's a swine, but someone's got to do it

> I'M BOUND TO BE ONE OF THE FIRST TO GET INFECTED AS SUFFERERS COME IN FOR ADVICE

We are to act as a distribution point for Tamiflu, supplying the drug to 'patient buddies' on receipt of a signed order from a GP. The local enhanced service will pay me £3.50 per supply. So far, so good.

This will work until I have to stay at home because I've contracted swine flu myself. Then I presume the pharmacy will close because there won't be enough 'flu-free' locums to cover. I'll be interested to see who qualifies as a "suitably experienced" person to practise as a pharmacist in case of emergency (C+D, May 9, p5). I'd like to see anyone other than an experienced community pharmacist manage a day in a pharmacy without causing serious harm.

If the PCT has made plans in case things get that bad, I expect to be one of the last to know as usual. Perhaps I could lock myself in the consultation room, check scripts through the glass in the door and communicate via telephone. I'm bound to be one of the first people to get infected, as sufferers and their friends and family come in for advice and remedies. That's part of the job, I suppose, and I attribute my efficient immune response to my continual exposure to all sorts of germs in the workplace.

But it seems that some multiples and supermarkets don't consider an important role in tackling swine flu as part of their job. They have been refusing to take part in this enhanced service for some reason best known to themselves. The supermarkets don't want to allow swine flu into the food chain was one excuse I heard. An unwillingness to expose yourself to infectious diseases should prevent you from operating a community pharmacy in my opinion.

An active role in tackling a flu pandemic should be our duty, and we should be setting an example to the community. If pharmacies won't act as distribution points for Tamiflu, why should libraries and other public places volunteer? Nobody wants their latest Catherine Cookson covered in flu virus.

I'm struck by the apparent piecemeal approach to the planning for a pandemic that we've known has been on its way for some time. Every PCT seems to have its own ideas and Scotland and Wales have other ideas again.

Anybody living near an administrative boundary could be in for a confusing time of things. I'll be telling people not to worry too much, while Tamiflu can provide some relief, it's not worth doing anything silly to get hold of some.

I've still heard nothing but jokes from patients in relation to swine flu. That's a much better reaction than the blind panic that's bound to ensue when they realise the implications of a full blown pandemic.

Crown Court puts PCTs to shame

Towards the end of 2007, a pharmacist was suspected of not submitting to the PPD prescriptions for low value medicines he had dispensed. He was accused of pocketing prescription charges paid by non-exempt patients.

Over a six-month period, undercover police officers presented prescriptions. Counter fraud investigators went to the PPD offices each month to look through the prescriptions that arrived there. Out of 45 forms in the six-month period, the investigators found 36. The pharmacist was arrested and charged with fraudulently withholding the other nine forms.

The local PCT decided to use powers in the National Health Service Act to suspend the pharmacist from practising. The law now permits a PCT to convene a hearing at 24 hours' notice if satisfied suspension is necessary for the protection of members of the public or is otherwise in the public interest. There is no right of appeal against a PCT suspension.

Some PCTs do not allow pharmacists legal representation at suspension hearings. Whether that satisfies the legal principles of natural justice remains unclear and when a suitable case comes up, I look forward to having an opportunity to challenge a PCT suspension in a High Court test case.

Last autumn, the pharmacist faced trial in the Crown Court. The Crown Prosecution Service did not realise that just because investigators did not find nine forms in various names out of many thousands submitted, this did not mean the forms were not there. It only means they were not found during a relatively brief search at the PPD. After hearing the prosecution evidence, the judge decided that taking the prosecution case at its highest, the evidence against the pharmacist was so tenuous that the jury could not properly convict. He found that the pharmacist had no case to answer and directed the jury to return a verdict of not guilty.

The differences between the PCT and Crown Court proceedings could not be more glaring. The PCT was able to make a decision on the basis of suspicion, with a low burden of proof and affording no time to prepare a defence, whether or not the pharmacist was allowed to have legal representation.

In the Crown Court, there was a proper opportunity to test the prosecution case and its deficiencies quickly became apparent. It seems to me that this case is one more example of how justice for healthcare practitioners has been sacrificed on the altar of knee-jerk reaction to the Shipman murders.

David Reissner is a solicitor and head of healthcare at Charles Russell LLP, where he is a partner

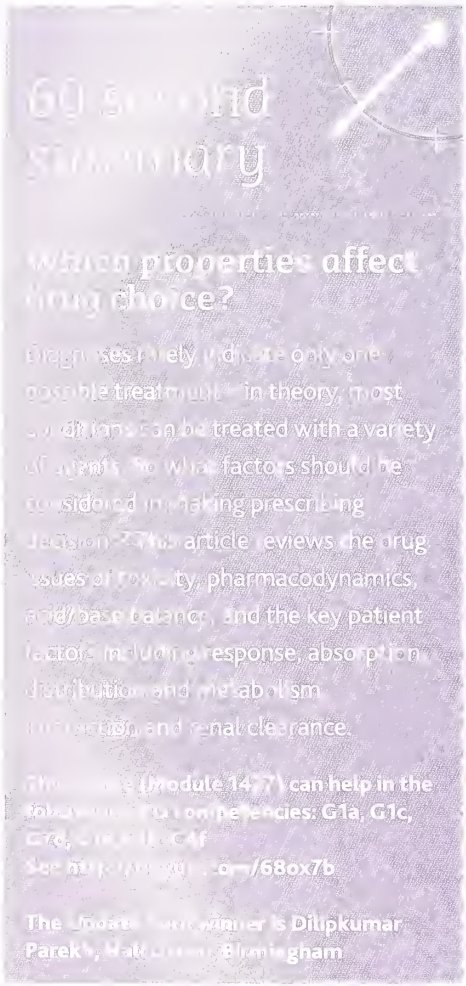
16.05.09

Features

Update

Factors influencing prescribing

Decisions depend on drug properties and individual patient characteristics



Dr Russell Greene, MRPharmS

Once a diagnosis is established, the prescriber should not simply turn to the appropriate page of the BNF and pick the first or cheapest drug listed. For example, in hypertension there are numerous classes of antihypertensive and within each class there is often a choice of several agents. Which should be used? Even evidence-based guidelines may not clinch the exact agent.

The clinical trials that underlie guidelines rest on principles that fall into two groups: drug factors such as mode of action and half-life; and patient factors such as age and renal function.

Drug factors

Pharmacodynamics and toxicity

Rarely, the diagnosis may indicate a specific drug, eg GTN in acute angina, but usually there are a number of possibilities, and pharmacological properties become relevant: for example, a cough suppressant may be preferred to a decongestant for unproductive cough. Receptor action may also be important, eg cardioselectivity in beta-blockers.

The therapeutic index must be evaluated: what is the risk-to-benefit ratio of treatment? A severe condition may justify using a very toxic agent, such as methotrexate in cancer, but the same agent must be carefully considered for a non-fatal illness such as psoriasis, however effective.

Biopharmaceutics

Formulation can affect bioavailability, which is particularly important for drugs with a narrow therapeutic index, especially when used to stabilise chronic conditions, eg phenytoin in epilepsy or theophylline in COPD. Formulation changes can increase or reduce absorption, causing either overdose or breakthrough of illness.

Pharmacokinetics

Within a similar group of drugs there may be a wide range of different physicochemical properties that could affect absorption, distribution, clearance and elimination.

- **Hydrophilic/lipophilic balance**

The characteristics conferred by predominant hydrophilic properties (ionisable, water soluble, eg aminoglycoside antibiotics, aspirin) or lipophilic ones (non-polar or fat-soluble eg general anaesthetics, warfarin) are summarised in table 1 below. These are particularly noticeable within a series of otherwise similar drugs such as beta-blockers.

Most drugs need an element of each group of properties: lipophilic, to cross membranes; hydrophilic, for distribution in body fluids.

Lipophilic drugs cross the blood-brain barrier easily. They reside in body fat and so may have a long half-life, eg diazepam. If an active metabolite is also lipophilic, there is further prolongation, eg carbamazepine. Ionised or hydrophilic drugs penetrate membranes poorly, and so have poor bioavailability.

Hydrophilic drugs, eg atenolol, are usually cleared rapidly by renal excretion, giving them a shorter half-life. Lipophilic drugs, eg propranolol, are usually metabolised by the liver to produce a

Table 1 The effects of hydrophilic and lipophilic properties in the body

Property	Lipophilic	Hydrophilic
Membrane penetration	Good	Poor
Oral absorption	Good	Poor
Main distribution	Body fat	Body water
Blood–brain barrier	Cross	Does not cross
Main clearance	Hepatic	Renal
Clearance dependent on	Liver function	Renal function
Half-life	Longer	Shorter
First-pass effect	Possible	–
Plasma protein binding	–	Possible
Possible interactions	Other hepatically metabolised drugs	Other protein-bound drugs

Your CPD menu

MORE UPDATE ARTICLES
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MUR TIPS AND RESOURCES
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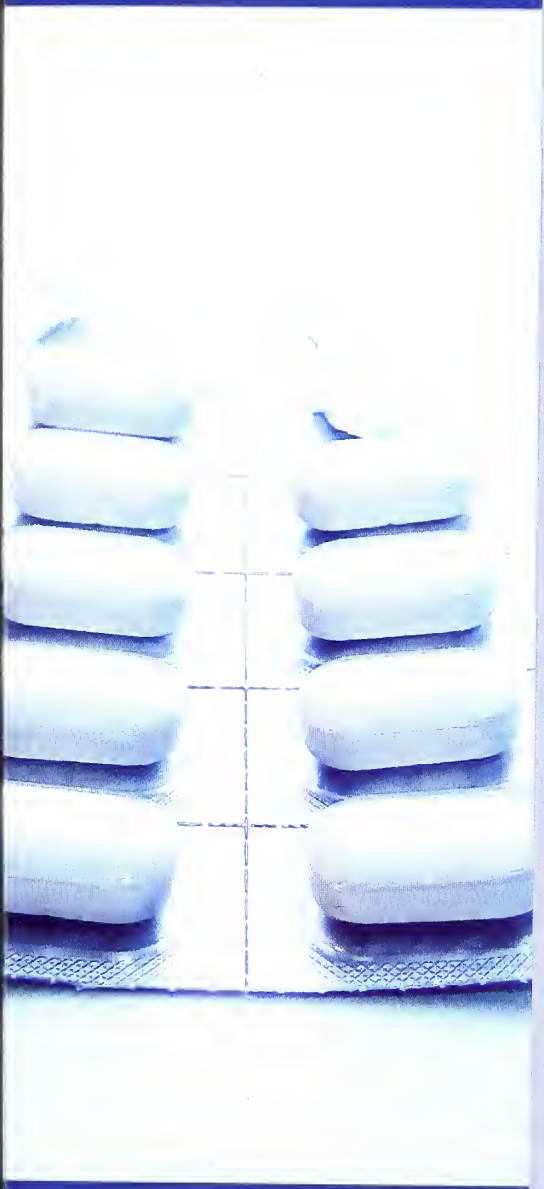
RBS
The Royal Bank of Scotland

Developing finance support for pharmacy



Pharmacy is a growing sector with constant demands for working capital and funding to take on larger customers in the social care sector, clinics, and to free themselves to source drugs and supplies on the open market. Add this to the challenges brought about by Category M and we have needed a new approach to provide economic and reliable sources of finance.

RBS
The Royal Bank of Scotland

TOP TIPS

A breakdown of some top tips below –

- Cash is king – keep control of your cashflow by having the right management information and systems in place. They'll allow you to act on warning signs before they become a problem.

- Talk to us – there is a lot of support available to small businesses. RBS Invoice Finance has a pharmacist working with us to provide a "businessman's" perspective to the shape of facilities. RBS has 2,300 locally based business managers offering customers free face to face advice, and a helpline with a pharmacist on the end of the phone.

- Look at your costs – look at purchase costs as well as staffing and fixed costs. If sales fall avoid taking on unprofitable business but do consider new areas.

- Look at new areas of business – each environment is different but explore new clinics, supplies to larger customers and care homes, work out the capital required and consider the payback both short and medium term, or the impact of doing nothing.

RBS Invoice Finance has been working hard to develop support for pharmacists and is pleased to link up with Richard Hutton BSc MRPharmS to bring his experience as a qualified pharmacist to our teams across the UK.

Supporting businesses and helping them review their financial options is our priority at RBS. So what does this mean for pharmacists and what products will help your business?

Questions you should be asking yourself include:

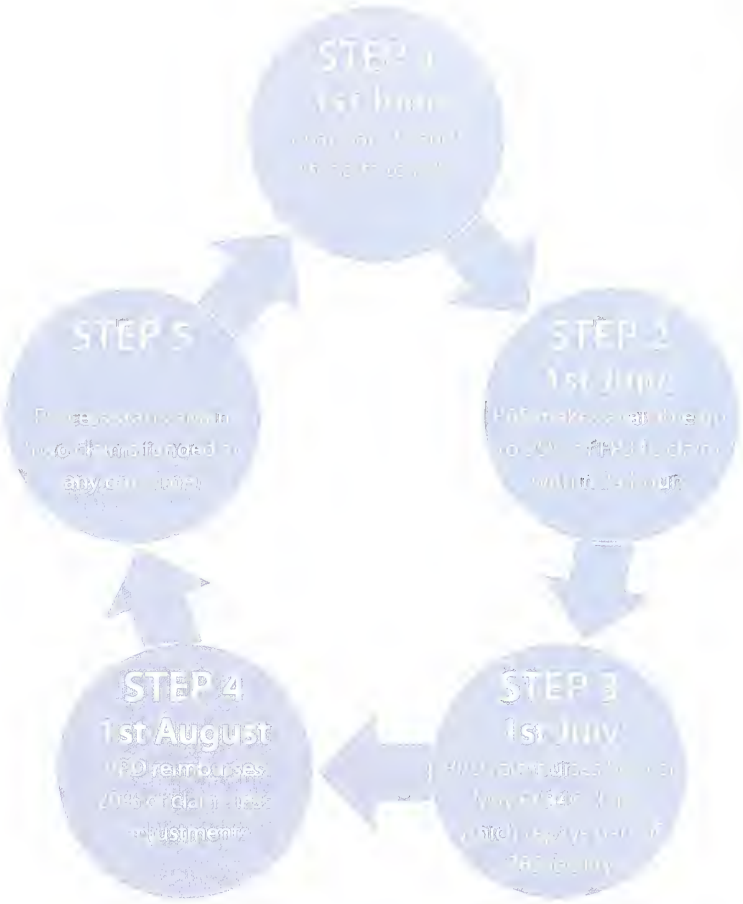
- Is the Category M reimbursement tariff causing you cashflow problems?
- How can it be more efficient?
- Will cashflow become a problem in the coming months?
- How can I fund expansion of new services?
- How can I have the flexibility to purchase supplies on the best terms?

Cashflow is critical to every business and without it a business can't pay its workers or suppliers and ultimately cannot function. Some firms do not anticipate all their expenses and discover when it is often too late, that their business is at risk. One of the most important considerations for firms is to put cashflow first, profit second and turnover last.

So what steps should pharmacies be looking to take to protect their future and ensure they are well placed to tackle the issues around Category M? At RBS Invoice Finance we have developed a new service tailored to ease the cashflow pressures these issues can cause. The service works on the basic principle that as soon as a pharmacy notifies the prescription figures (FP34C), then RBS will provide up to 95% of the monies due immediately. For example, for a pharmacy turning over £120k a month with two claims outstanding for two different months, this could mean raising up to nearly £200k of finance. So rather than waiting for payments of funds held up in the Prescription Pricing Division, funds for prescriptions are received almost immediately.

Improving your cashflow

Pharmacists can receive payment for dispensing within 24 hours instead of the usual two month wait. See below example of how RBS can help.



To find out more about how our specially tailored service can help your pharmacy business, please call RBS Invoice Finance on 0800 711911 or visit www.rbsif.co.uk/pharmacy

Case study – **Whitworth Pharmacy**

RBS Prescribe Funding Solution for Expanding Pharmacy

The late owner of Whitworth Chemists Limited John Whitworth initially opened the Whitworth Pharmacy business in 1967, eventually forming the wholesale pharmaceutical company Doncaster Pharmaceuticals Limited. Following the sale of Doncaster Pharmaceuticals in 1999 John formed Whitworth Chemists Limited starting with two pharmacies. The number of outlets has increased since 1999 to 32 based around the M62 corridor and are the result of a number of acquisitions, which were supported by their bankers The Royal Bank of Scotland (RBS). Today the business is run by Managing Director Richard Bradley (the son of John's wife Dorothy) who has extensive experience in the industry having worked in the UK and the US. The Whitworth Group today employs circa 230 staff at 32 locations together with a Head Office team based in Scunthorpe.

RBS' team of invoice finance specialists have worked with Whitworths since 2005 when they reviewed the company's financial package and tailored an invoice finance facility which continues to make a positive impact on the operation of the business and assisted the business' cashflow, particularly during the major acquisition phase. Invoice discounting is one of the fastest growing methods of business financing, allowing a business to immediately realise the cash benefit of its sales. In addition, businesses don't need to renew it every year, as they would do with an overdraft. It is there as long as it is needed removing some of the hassle often associated with financial packages.

Richard Bradley, Managing Director at Whitworths, commented:
"Keeping control of your cashflow is very important when you are growing the business and it is important to keep pace with it. It has been particularly important recently during a period of uncertainty in terms of cashflow caused by fluctuations in remuneration due to Category M. Refinancing can be a headache for a number of businesses but with our robust expansion plans it was important to select a partner of the calibre of RBS Invoice Finance for this next stage of our development. When we first approached them in 2005 their team of specialists straight away explained the options available and were able to tailor a facility to meet our requirements, enabling us to reap the benefits of the invoice finance facility put in place."

Pauline Tulip, Relationship Manager at RBS Invoice Finance, said:
"In under ten years this dynamic business has expanded rapidly through acquisitions and they continue to grow. We are delighted to continue our relationship with Whitworths and work closely with the management team to ensure our facilities continue to meet the needs of the business. The rewards of the invoice finance facility have given the business the headroom to proceed with the acquisition strategy from a sound and secure platform. We look forward to a continued long-standing partnership with Whitworths."

hydrophilic molecule that is more easily excreted renally; this introduces some delay. They are also more likely to suffer first-pass hepatic metabolism, reducing bioavailability.

Although both hydrophilic and lipophilic molecules are freely filtered at the renal glomerulus, the latter are equally freely reabsorbed from the tubules, so their net renal clearance is slow. In contrast, hydrophilic molecules are not reabsorbed and so are more rapidly excreted.

- **Acid/base balance**

Acidic drugs, eg aspirin, are generally more highly bound to plasma albumin, giving a lower volume of distribution, ie they tend to stay in the plasma rather than distribute to the tissues. Basic drugs, including many CNS-acting agents such as phenothiazines, are theoretically more prone to binding to plasma acid glycoprotein, although albumin also has binding sites for basic drugs. Plasma protein binding reduces the free (unbound) drug plasma concentration, and thus both drug activity and clearance, because it is only the free drug that is available for clinical effect, hepatic extraction and renal excretion.

Urine pH can affect clearance. More acidic urine promotes the clearance of basic drugs, and vice versa. This is the basis of forced acid or forced alkaline diuresis to treat poisoning, eg urinary alkalinisation for barbiturate or aspirin overdose.

To illustrate how all these factors interact, consider a drug intended for the oral prophylaxis of recurrent urinary tract infection. To be effective it must be well absorbed, not significantly metabolised by the liver and be excreted in antimicrobially adequate concentrations in the urine. For long-term compliance, a once-daily drug or formulation would be preferred.

Patient factors

Once the choice has been narrowed down by the drug factors, we need to consider how individual patient characteristics might modify this because of variations in drug response (table 2 above right) and handling (see table 3 online).

Response

- **Age** The elderly and the very young respond differently to many drugs, eg aggression is seen in some elderly patients taking benzodiazepines. Impaired physiological or homeostatic mechanisms among the elderly may cause an exaggerated hypotensive effect with vasodilators or diuretics. Genetic or racial differences may affect drug response eg thiazide diuretics are more effective antihypertensives in Afro-Caribbean patients and beta-blockers less effective.
- **Compliance** If unexpected responses occur, compliance should always be considered. A change in drug or formulation may encourage better compliance eg a long-acting, once-daily form for essential hypertension. The patient should be asked whether an inappropriate dose or unexpected adverse effects are to blame for reduced compliance.
- **Concurrent diseases** A patient's sensitivity to some drugs may be altered by certain diseases, eg the myocardium is more sensitive to digoxin after infarction or in thyroid imbalance. Beta-blockers are contraindicated in asthma, while digoxin toxicity is increased in hypokalaemia.
- **Tolerance** Prolonged exposure to a drug may cause dose escalation or diminishing effect, eg prophylactic nitrates without daily washout periods.
- **Interactions** A drug history should warn of possible drug-drug interactions. Most involve pharmacokinetic interference (below) but it may also be pharmacological, as when taking antagonistic drugs (eg corticosteroids and thiazides both antagonise oral hypoglycaemic drugs), or additive or synergistic, such as a sedative OTC antihistamine taken with an anxiolytic.

Finally, with women, the possibility of the drug having an effect on conception, pregnancy or breastfeeding requires consideration.

Table 2
Variations in patient response can be caused by:

- **age**
- **compliance**
- **concurrent disease**
- **concurrent medication**
- **ethnic/genetic variation**
- **pregnancy, breastfeeding**
- **tolerance**

Handling

- **Absorption** Only extreme age affects oral absorption. However, gut disease can affect it (eg vomiting, diarrhoea). Potential dietary interactions include tetracycline absorption impaired by milk or antacids. Insulin absorption from a limb injection site is more variable than from an abdominal one, because limb perfusion varies with physical activity.
- **Distribution** The elderly have a relatively smaller proportion of water in their body than middle-aged adults, whereas the young have a larger proportion. This affects hydrophilic drugs. Conversely, both the elderly and the very young have reduced plasma albumin, which reduces drug binding. The patient's hydration (eg oedema) and nutritional state (eg malnutrition) would have similar effects. A large volume of distribution results in lower plasma levels and vice versa.

Local blood circulation may be impaired, eg it is difficult to treat an infected diabetic foot with systemic antibiotics because of peripheral vascular disease.

The blood–brain barrier impedes hydrophilic molecules, but this effect is reduced by inflammation, so in meningitis most antibiotics can reach the brain. Pus in wounds and boils is poorly penetrated by some antibiotics, and sputum concentrations are frequently lower than plasma concentrations.

Interactions may result from displacement from plasma protein. A drug will only cause a clinically significant displacement of another if both are avidly bound to the same site and are in high plasma concentration. Further, clinical significance will usually only occur if the displaced drug has a narrow therapeutic index, eg anti-epileptics.

- **Hepatic metabolism** The slow decline in liver function with age leads to reduced levels of serum albumin and decreased hepatic metabolism. These may combine with other age-related changes to influence the availability of many drugs. Interacting factors and individual variation make it difficult to predict what the effect will be in a particular patient, so caution is required.

Liver function needs to be considerably impaired, by age or disease, before significant effects are seen. The greatest effects occur with highly metabolised drugs.

- **Drug metabolism interactions** Table 4 (online) lists some important drugs affecting hepatic enzymes. Enzyme induction reduces drug activity, but this is clinically significant only with drugs with a narrow therapeutic index or when loss of activity severely compromises the patient, as with warfarin. The toxicity of some drugs is enhanced by a toxic metabolite eg paracetamol and isoniazid.

Enzyme inhibition may increase drug activity or toxicity. Again, drugs with a narrow therapeutic index are most affected, eg phenytoin.

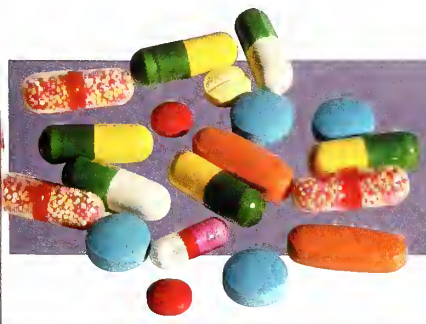
Enzyme inhibition occurs rapidly and reversibly, but induction depends on new enzyme synthesis, so the effect takes some time to become apparent and to wear off (see table 4 online).

- **Renal clearance** Ageing and renal disease cause a decline in renal function. The primary concern then is for hydrophilic drugs, eg gentamicin, which is 98 per cent renally cleared. Hepatically cleared lipophilic drugs are unaffected. For drugs cleared partially by both routes, eg digoxin in which clearance is 15 per cent hepatic and 85 per cent renal, only the renal component is affected and must be considered when adjusting dosage.

When cleared more slowly, the same dose will be retained longer, ie the half-life increases and thus normal dosing raises plasma level. The changes will be in proportion to the fall in GFR or creatinine clearance. Consider a patient who has a creatinine clearance of 60ml/min (half normal), taking a drug that is cleared 100 per cent renally. The dosage reduction required to give normal plasma levels should be 50 per cent. But if the drug is only half cleared by the kidney, the dose reduction needs to be only half that ie 25 per cent.

Russell Greene BPharm, MSc, PhD, MRPharmS, is senior lecturer in clinical pharmacy, King's College London.

Get the full version of this article, with extra tables and references, at www.chemistanddruggist.co.uk/update



NEXT WEEK:
Update will look at drugs that might cause pain as a side effect

Factors influencing prescribing – recording

Reflect

Why might a hydrophilic drug be rapidly excreted? How does the acidity of a drug affect its distribution? Which drugs are affected by a decline in renal clearance?

Plan

This article considers the factors that affect drug choice when prescribing ie drug properties such as bioavailability, and patient factors such as age and hepatic metabolism.

Act

Read more about prescribing in the elderly and the drugs that may cause problems, on the East Kent Hospitals University website
http://tinyurl.com/cj9qey

The Patient UK article Prescribing for the Older Patient includes a list of potentially inappropriate medications for the elderly as its first reference
http://www.patient.co.uk/showdoc/40000135/

Revise your knowledge of how renal impairment affects drug prescribing by reading the Patient UK article at
http://www.patient.co.uk/showdoc/40025092/

Examine your next few prescriptions for elderly or renal patients and think how prescribers may have made their choice. How could you use the information in this article: would it make drug reactions easier to spot? Or help when carrying out MURs?

Evaluate

Are you now familiar with the factors that affect drug choice when prescribing? Are you aware of the problems that prescribers for the elderly and renal impairment must consider?

Practical Approach

Optimum dose timing

Joanna Savage, pre-registration pharmacy trainee at the Update Pharmacy, has made two presentations to the GP practice to which pharmacist David Spencer gives prescribing advice. The presentations were based on a project she did as part of her previous pre-reg training in a hospital, on optimum dose timing of drugs with a once-daily dose.

Joanna has been invited to give a third and final presentation on hypoglycaemic agents, asthma treatments and NSAIDs. As before, Joanna's recommendations are based on trial evidence and manufacturers' recommendations.

Question

What information did Joanna give for sulphonylureas and thiazolidinediones; terbutaline, leukotriene receptor antagonists and theophylline; long-acting NSAIDs and antidepressants?

Answer

- **Hypoglycaemic drugs** Hypoglycaemic effects of glimepiride, pioglitazone and rosiglitazone do not depend on time of administration.[1] However, glibenclamide, gliclazide (both standard and modified release formulations) and glipizide should be given once daily with breakfast.
- **Asthma therapy** Bambuterol (terbutaline prodrug) and montelukast are recommended to be taken at bedtime. In a controlled trial, evening administration of bambuterol in comparison with morning administration produced enhanced early morning bronchodilator effect. This appeared to be due to the elevated terbutaline level maintained during the morning hours.[2] Evening dosing seems preferable for once-daily

For Practical Approach references see

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part 3

theophylline preparations, in order to achieve higher therapeutic levels at night and in the morning when asthmatics are at the greatest risk of developing bronchospasm.[3,4]

- **NSAIDs** Evening dosing of indometacin sustained release was most effective in osteo-arthritis patients with predominant nocturnal or morning pain, whereas morning or noon ingestion was most effective in patients with maximum afternoon or evening pain. The analgesic effect was increased by about 60 per cent when the NSAID was taken at the preferred time (about six hours before the usual time of worst osteo-arthritic pain) compared with when it was ingested at the non-preferred times of the day.[5] Adverse effects of indometacin were consistently greater in occurrence and severity if the sustained release capsule was ingested in the early morning rather than at any other time of day.[6] Morning dosing of ketoprofen c/r (200mg) increased efficacy without reducing tolerability in patients with osteo-arthrosis when compared with evening dosing. The reduction in the degree of pain in the afternoon and in the evening was significantly higher with a morning dose.[7] However, greater efficacy might need to be balanced against increased adverse effects as, in another trial, incidence and severity of these were twice as great in patients taking ketoprofen in the morning than at night.[8] Evening dosing of NSAIDs might be better tolerated by most patients, and those with a high risk of GI irritation should be advised to avoid taking an NSAID early in the morning.[9] The efficacy of celecoxib 200mg once daily in management of osteo-arthritis of the knee or hip appears independent of dosing time.[10]

References at: www.chemistanddruggist.co.uk/practicalapproach

This article can help with the following CPD competencies: **G1a, G1c, G1e, G1s, G2h, G6p, G8g, C4b.**
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Getting commissioned

A 10-STEP GUIDE TO for an obesity service

Central Lancashire LPC has delivered a pharmacy-based weight management service. Vice-chairwoman **Liz Stafford** sets out a 10-step guide to the know how

1 Is this a significant priority in your PCT?

Study the PCT strategic commissioning plan and commissioning intentions, the PCT CVD strategy, PCT obesity strategy for primary and community care, local area agreement and vital signs indicators, health inequality report, audit commission report, and PBC commissioning plans – if these are all accessible.

Use the ready reckoner in the DH toolkit – Lightening the load: Tackling overweight and obesity – to calculate the obesity prevalence. Go to the National Heart Forum website at www.heartforum.org.uk.

Identify which targets your service will help to achieve.

2 Survey local contractors

Check if they want to deliver weight management as a commissioned service. Some may already offer private services. However if there is a need for a commissioned service the public can access, free at the point of delivery, there is no reason why the two should not be offered side by side providing there is a clear demarcation of services and the choice of services is clearly explained to the public.

Map 'willing contractors' along with the details of any private weight management services they already provide.

3 Communicate your plan

Consider all the stakeholders you need to engage to confirm your intention to develop a business case for an NHS commissioned pharmacy-based weight management service.

These may include, directors of public health, commissioning, head of primary care, community pharmacy adviser, head of medicines management, obesity care pathway lead, head of dietetics, PEC GP or medical adviser. Work with your PEC pharmacist if you have one.

'Sell' how a pharmacy weight management service will support PCT and local authority targets, especially in areas of health inequality.

Prepare your pitch, quoting examples of services in other PCTs and of evidence or benefits gained elsewhere. Seek stakeholder support – and ask them what is happening already within the PCT, for example is there a list of existing weight management services and healthy living initiatives? Do they have, or are they developing, a care pathway for weight management? Ask for public health data eg numbers registered as obese on GP practice registers.

Seek to understand the reasons for any resistance you may encounter and find the best ways to deal with this.

4 Identify a champion

Get someone at PEC board or PCT board level to support your case. If possible, find a GP champion too. Work with a PCT lead, such as a community pharmacy adviser, obesity care pathway lead or commissioning lead and a small project team to develop the service according to local requirements.

5 Commissioning process

Clarify how this works. Ask how bids should be submitted and if there is a local template that should be used. Clarify timelines for bids to be submitted, before the next planning round. Consider the number of pharmacies in the first project wave and how long it should run before evaluation. If project funding is available, ensure that funding is identified in the operating plan for the following year for the sustainable commissioning and further rollout of the service. Survey patients/public to find out what they want from a weight management service. Use this to support your case and to design your service. Develop a questionnaire with the PCT.

6 Developing the service

Gather information on existing services eg Coventry PCT, Central Lancs PCT. Learn best practice, issues etc from those already involved. Work collaboratively with the local team to decide on a service model that best suits local needs, for example one that GPs will refer patients to – and one that can be integrated into the overall care pathway for weight management. Seek feedback from GPs, dietetics and others about your service model – and include their input where possible. Agree how your service will be evaluated.

7 Accreditation and training

Depending on the service model selected, identify what in-house PCT training may be available, as well as external options, such as CPPE's weight management module.

8 Bid and costings

Using local data and information to build your case, highlight the relevant policy and targets. Cost will depend on the service model, what validated equipment the PCT may provide and fund, the number of pharmacies in the first wave, cost of training, materials, backfill for training, evaluation. Where the PCT already has suitable in-house training and materials, cost savings can be made. Clarify to others how community pharmacy operates and the reasons for how costs need to be structured. Refer to the NPA Brief Guide to Pharmacy Obesity Services; also the NPA Template Business Case & Guidance for community pharmacy obesity management service at www.npa.co.uk.

9 Present to PEC board

Present the case to the PEC board – or ask a PCT lead or a PEC member to do this on your behalf to gain recommendation for this service to move to the commissioning stage. Ensure it is written into the PCT strategic plan and operating plan.

10 Be persistent

Don't underestimate how long it may take. Keep contractors updated.

CREDIT CRUNCH SURVIVAL GUIDE

PART EIGHT

SAVING TAX

Your pharmacy is your pension and a few simple tips can save you tens of thousands of pounds when you sell. **Anne Hutchings** explains the difference between share sales and asset sales and how to maximise your tax relief

Surprisingly, tax is often forgotten when pharmacists decide to sell their businesses. The main question is "how much can I get for my pharmacy?" rather than "how much will I have left after tax"?

Approximately 60 per cent of the pharmacy sales that we handle relate to pharmacies owned by a limited company. In this situation, a decision has to be made by the company owners about whether to retain the company and just sell the assets such as the goodwill, fixtures and fittings and stock or whether to sell the whole company via a company share sale.

If you don't structure this carefully in the right way, you could end up being taxed twice, as demonstrated in case study 1.

CASE STUDY 1

Mr Jonas of Jonas Chemist Ltd agreed to sell the goodwill in his pharmacy for £500,000. The pharmacy was started from scratch many years ago and therefore had no acquisition cost.

The options

Either sell the shares in the company or sell the assets and keep the company. In this case study, to keep it simple, costs etc relating to the sale have been ignored.

Share sale

Mr Jonas sells the shares and makes a gain of £500,000. He qualifies for Entrepreneurs' Relief, resulting in a tax bill of only 10 per cent amounting to £50,000. This leaves Mr Jonas with £450,000 in his pocket.

Asset sale

The company Jonas Chemist Ltd sells the goodwill for £500,000. The gain of £500,000 will be taxed at corporation tax rates along with the trading profits, which were £50,000 for the period. The gain on the sale of the goodwill would be taxed as follows:

The first £300k is taxed at 21 per cent therefore after deducting the £50k trading profit the gain on the goodwill will be taxed at:

£250,000 at 21 per cent	Tax £52,500
£250,000 at 29.75 per cent	Tax £74,375
Total Tax	**£126,875**

After deducting this tax from the goodwill value of £500,000, this would leave £373,125 in the company. If Mr Jonas wants to take the money out of the company for his own use he will have additional tax to pay of least 10 per cent amounting to £37,312 (£373,125 x 10 per cent). The amount Mr Jonas would actually be left with is only £335,813.

In this example selling the assets instead of the company shares would cost an extra £114,187 in tax.

THE SALE OF on your pharmacy

Could you sell the assets rather than the company shares?

There are instances where it may be better, for example:

- If you have a very high base cost in the company for the goodwill so it won't make much difference to you from a tax point of view. You may also be able to negotiate a slightly higher price from your buyer if it's an asset sale.
- If you want to roll the gain into another business. There are many qualifying conditions, so check in advance that your proposed new business will qualify.
- If you have a company with a number of pharmacies and/or other assets and you are just selling one pharmacy it may be cheaper and easier just to sell the asset rather than trying to restructure the business.
- Where you have assets in your company other than the pharmacy, such as property or investments, you should review this well before you put the business on the market so that you have the opportunity to extract assets or restructure the company in a tax effective way.

A typical example is where the company owns the freehold premises as well as the pharmacy but the vendor wants to retain the premises in his/her name and create a lease for the new owner. Depending on the value of the premises and the original cost, it may not be very expensive to extract the property from the company. The pharmacy can then be sold via a company share sale.

If you are transferring a property from your company to your own name, it is important to obtain an independent professional valuation of the property in case of a dispute with the Revenue. Tax will be payable on any gain. Also allow for stamp duty at rates of between 1 and 4 per cent depending on the value of the property.

Many people who are selling their company have accumulated surplus cash. This creates a tax planning opportunity as illustrated in case study 2 below.

CASE STUDY 2

Jonas Chemist Ltd has surplus cash of £80,000 in the bank after taking into account the company's liabilities. Mr Jonas could take this as a dividend on which tax will be paid at 25 per cent, assuming that Mr Jonas is a higher rate tax payer. Or if the buyer of his company agrees, the £80,000 can be added on to the sale price and Mr Jonas will only pay capital gains tax on it. In Mr Jonas case he is entitled to Entrepreneurs' Relief so his capital gains tax rate is only 10 per cent. Therefore:

Cash as dividend £80,000 x 25 per cent =	Tax	£20,000
Cash as part of the share sale £80,000 x 10 per cent =	Tax	£8,000
	Tax saving	£12,000

Entrepreneurs' Relief and business restructuring

The main allowance for business owners is Entrepreneurs' Relief, which allows gains of up to £1 million to be taxed at an effective rate of 10 per cent. Most pharmacists should qualify for this providing they have been trading for at least one year. If you own more than one business, this can be claimed on more than one occasion but the overriding lifetime limit is £1m.

It may be worth re-arranging your affairs if the gain on your pharmacy sale is over £1m to take advantage of the tax savings. For example, a sole trader could consider making their spouse a partner (in England and Wales all partners must be pharmacists, but in Scotland a non-pharmacist can be in partnership with a pharmacist). Alternatively a sole trader could consider transferring their business into a company as there is not a restriction on non-pharmacists being shareholders.

If you do restructure your business in this way, remember to allow plenty of time before selling your business to ensure that the 12-month ownership criteria is met. The new business owner should have some involvement in the business, although this could be fairly minimal. With a potential tax saving of £80,000 on a gain of £2m, this is worth serious consideration.

There are many opportunities for saving tax on a pharmacy sale. This article was only able to cover a few ideas and before taking any action resulting from this article you should take expert advice from a tax specialist.

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PR potential

Passionate about pharmacy? Why not tell the rest of the world about it? **Zoe Smeaton** looks at pharmacists working in communications

Do you know your Apprentice from your Desperate Housewives? Would you be happy being pushed in front of a camera at 6am? And could you cope with being put on the spot in front of thousands of people?

If the answer to these questions is yes, then a career in communications could be for you. There are many roles for pharmacists in this area, from working full time in one of the major pharmacy organisations, to freelancing or making local radio appearances alongside the day job.

David Pruce is director of policy and communications at the RPSGB and says he got into communications "by mistake". The Society had trained all their senior staff in media skills, but he was thrown into the spotlight unexpectedly after a Which? investigation into pharmacy.

He explains: "I had to do something like 10 live and pre-recorded interviews as my baptism of fire. It was scary, but the adrenaline rush when you get it right is amazing."

And this, he says, has always been his favourite thing about the job. "Just knowing that you are communicating with hundreds or even thousands of people and you have got across the message that you intended is such a buzz."

Nargis Ara is a pharmacist who now works as a consultant and frequently appears in the media to give an expert opinion on health stories. After completing her pharmacy degree Ms Ara worked in academia, and her switch to the media came after she appeared on reality TV show The Apprentice.

She agrees that being in the spotlight can give a real adrenaline rush, but warns the work can also be quite unpredictable. "It can be quite random as to who calls," she says.

David Pruce: a communications role can give an "adrenaline rush"

This unpredictability extends to the interviews, too, says Mr Pruce, and he warns that you do need to be able to think on your feet. Sometimes you might go into a studio prepared for one line of questioning, only to be faced with something completely different.

And you'll need to be prepared to talk about things that you might not necessarily be an expert in. Ms Ara has commented on everything from forensic science to foot and mouth disease and explains: "Stories are not necessarily anything related to something I would have learnt in my pharmacy degree, so I have to extrapolate my knowledge to get my head around things."

You could also have to face some more unusual questioning, such as the time on local radio when Mr Pruce was asked whether he preferred The Apprentice or Desperate Housewives.

"I hadn't watched either of them, so I said The Apprentice, but then they asked me who had been kicked off last night and I had no idea!" he laughs.

As well as being able to cope with the unexpected, Mr Pruce says one of the most important skills needed to work in this area is the ability to present information succinctly. But he thinks this is a skill you can develop with practice. Offering to do things such as presentations, or even lectures, would be a good start.

When you are confident in your abilities, he adds: "The best thing to do is to get yourself into a position where you can be a spokesperson for something, even if it is just your branch." This will give you experience talking to journalists and improve your confidence. Mr Pruce advises: "You can often get into your local papers, which are often much kinder than the nationals. And be prepared to talk on the local radio, too; the more you do at a local level, the more experience you will get."

It's also very important to be aware of the different types of media, and how they might present things. As Mr Pruce says: "When you're talking to certain people everything has to be measured, other people you know are going to be a little bit kinder."

So if you're looking to add a little excitement to your career, and think you could cope with the unpredictability of the role, then a foray into communications could be the right step.

And the beauty of it is that you can start on a small scale before you commit to a full-blown job change. Pharmacists regularly appear in their local papers or on the radio and, who knows, next time it could be you in the spotlight.

CAREER TIP OF THE WEEK

"Job ads often sound as if they are looking for a superhuman candidate. But don't be too easily put off from applying – if you're not in the game, you can't win it."

From Brilliant CV, by Jim Bright and Joanna Earl

www.chemistanddruggist.co.uk/booksforjobhunters

Your questions answered

I'm not happy [illegible] want to look for something new, but would it be foolish to leave a secure position in this economic climate?

Boots professional resourcing manager Karen McGinty responds:

Firstly, you need to identify what is making you unhappy. You may find it is something you can fix and an external move is not required.

A recent study has found that those happiest in their work have a good work/life balance and an interest in what they do for a living.

When one of these elements is lacking, the first reaction can be to move on rather than to address the issues.

The usual first response is to blame others for your work volume and extra hours. But, mostly, the only person who can control your working week is you!

Take time to reflect on your working week. Make a list of the hours you work – and not just how many hours you are at work. If you find that you really do have too much work for your contracted hours, address it with your line manager. But most people find making this list identifies ways of using their time more efficiently, which reduces additional hours.

If, however, after looking at your current role in this detail, you find that you still want to move, don't let the economic climate worry you too much. You will still find there are plenty of companies who will continue to offer job security. The old notion of 'last in, first out' does not apply to most modern companies as they will invest in their best staff.

With those who are happiest at their work usually being the best performers, it is in everyone's best interest to create a good work/life balance.

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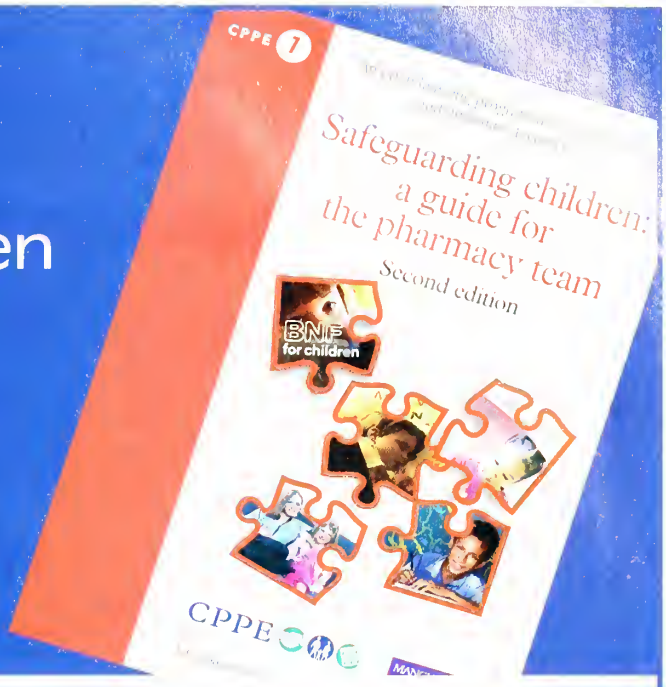

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Postscript...

Mike Hewitson's diary of a new pharmacy owner

The case of the exploding sausage

The Case of the Exploding Sausage: it sounds like a storyline from farcical 1980s sitcom Allo, Allo, but I promise every word of this story is true.

It was the Saturday before bank holiday; we'd had a busy morning but there were still plenty of people around so I decided to keep the shop open for a bit longer. A lady came in and asked: "Do you keep acidophilus?"

"We've got three different types; do you know which one you want?"

"I'm not sure," the lady replied. A confused and slightly embarrassed look came over her. Red-faced, she added: "My husband wants to put it in a sausage."

Not quite the answer I was expecting but, undeterred, I said that I didn't think it would matter too much as the acidophilus were all going to be fried alive as soon as the sausage was cooked. The lady then asked if she could buy saltpetre.

"Another sausage?"

"Salami," she replied. While my chemistry might be rusty, my history is not – could my customer be attempting to make gunpowder? It's the only use I know for the said ingredient. Maybe an Al-Qaeda plot to use exploding sausages as a weapon of mass destruction?

Not wanting to draw the attention of UN weapons inspectors to our little corner of Dorset, I politely said that I couldn't help with this request. This place gets stranger by the day...

> "WHILE MY CHEMISTRY MIGHT BE RUSTY, MY HISTORY IS NOT – COULD MY CUSTOMER BE ATTEMPTING TO MAKE GUNPOWDER?"

RAIDERS OF THE LOST ARCHIVES

C+D 1859-2009 Celebrating 150 years in pharmacy

How's your arithmetic, orthography and calligraphy, geography, geometry, Latin, Greek, French and German? If the answer is 'a bit rusty' or worse, you wouldn't make the grade as a pharmacist, according to Mr Haselden in the January 1860 issue of C+D.

The subjects were part of Mr Haselden's proposed syllabus for all pharmacists to study before they began their apprenticeship.

Other subjects included "practical pharmacy, chemistry and toxicology, material medica and botany".

But not all pharmacists thought making education compulsory was a good idea. "We conclude such remarks are absurd and monstrous," complained Mr T. Anderson. "If Mr Haselden thinks it possible to carry them out, why does not he recommend the Apothecaries' Hall as the asylum after all the expense and labour which he would necessitate?"

Mr Anderson continued to whinge: "It would not become the dignity of any man educated upon the system proposed by Mr Haselden to be a mere vendor of drugs, oils and paints.

"There is and always will be a necessity for a highly educated and intelligent, but necessarily limited class, who stand at the head of the profession... we have no faith in compulsory education for the large body of the profession."

PostScript is breathing a sigh of relief Mr Anderson didn't get his way, and that some sort of education is now expected for those wanting to practise pharmacy. That said, PostScript is also pretty relieved it wasn't forced to study geometry and Latin at university, too...

It's worse than that: he's dead, Jim!

PostScript avoided the cinema last weekend to escape the crowds of pudding-bowled, pointy-eared Vulcans and pasty-headed Klingons going to see the new Star Trek movie. Instead, it decided to check out the latest medical innovations... and ended up right back in the realm of doctors McCoy and Crusher.

In finest Star Trek technobabble, Imperial College London and Pfizer are currently working on a single nucleotide polymorphism (SNP) detector, a nifty little gizmo that checks a patient's genetic suitability to different drugs.

The hand-held device, called the Snip Doctor, will eventually be able to analyse a swab and rapidly churn out a result, helping GPs prescribe the most suitable treatment for the patient. It's unknown if it will make little 'whee-whoop' noises during the scan.

Here's hoping it will let the profession boldly go where no pharmacist has gone before.

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